

Monica Oganés & Associates Credit Card Authorization Form

PLEASE PRINT OUT AND COMPLETE
All information will remain confidential

Patient Name/ DOB: _____/_____

Cardholder Name: _____

Billing Address: _____

City/State/Zip Code: _____

Credit Card Type: _____ Visa _____ Mastercard _____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____

Amount to Charge: \$ _____ (USD) *

____ I authorize Monica Oganés & Associates to charge future sessions/fees to this card.

I authorize Monica Oganés & Associates to charge the agreed amount listed above to my credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement. **I understand that no refunds will be given once service(s) has/have been provided.**

Cardholder – Print Name, Sign and Date Below:

Signed: _____

Dated: _____

Name: _____

Once signed return the completed form to:

Monica Oganés
Monica Oganés & Associates
555 Winderley Place, Suite 300
Maitland, FL 32751

OR Fax (407) 809-5698

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